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FROM THE FOURTH GENEVA CONFERENCE ON PERSON CENTERED MEDICINE: MEASURING PROGRESS TOWARDS PEOPLE-CENTERED CARE

From "patient" to "person" to "people": the need for integrated, people-centered healthcare

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Abstract

Background and aim: The development of person-centred care is based on the principle that each human is a unique and autonomous individual, in illness as much as in health. In pursuing healthcare that is directed at people, the interdependence of human beings, and their broader environment are considerations which achieve immediate prominence. This paper proposes a theoretical framework which identifies the major elements of people-centered care. From this framework, "indicator-fields" are identified and a first exercise conducted in order to define specific indicators that could be used to assess the "people-centeredness" of health systems. We hope that our article will intensify the debate on people-oriented care, its components and its possible indicators and that it will contribute to the development of an instrument for the assessment of the *actual* people-centeredness of a given health system.

Methods: This paper builds on a literature-based theoretical exploration of the concept and a series of Delphi rounds with members of the International Centre for Primary Health Care and Family Medicine, Ghent University, a WHO Collaborating Centre on Primary Health Care.

Results: Five themes and sub-themes were identified which are essential in the assessment of the people-orientation of care. People-centered care is sensitive to and respectful of differences, while at the same time promoting basic universal rights and values (proportionate universalism), it is available, accessible and affordable for all; it is directed at the comprehensiveness of healthcare services; it considers the relevance and quality aspects of care, such as the responsiveness, adequacy and continuity of healthcare and it empowers individuals and communities through active involvement and participation. Consequently, possible indicators to measure a system's people-centeredness are considered and proposed.

Conclusions: Further systematic review of the literature and empirical research on the development of the theoretical framework of people-centered care and useful indicators to assess and measure it are needed to support health policy making.

Keywords

Clinical effectiveness, clinical indicators, equity, healthcare development, health promotion, health systems, outcome measurement, patient empowerment, patient-centered care, people-centered care, person-centered care, person-centered medicine, primary healthcare, public health, reductionism, social determinants of health

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Introduction

Recent decades have seen what some colleagues have described as a paradigm-shift from a singular focus on disease towards a focus on patient and person-oriented care. Until the Second World War, medicine was mainly focused on the eradication of (acute) diseases. The definition of health as formulated by the World Health Organisation (WHO) in 1946, emphasized that health was described not only by the absence of disease [1]. The emerging discipline of family medicine/general practice and psychiatry, questioned the reductionism of the biomedical model and stressed the importance of psychosocial factors [2,3], so contributing to the shift towards "patient-centered care" that today increasingly forms the basis of care in many medical disciplines. The International Classification of Functioning, Disability and Health (ICF) developed by WHO and endorsed by all WHO member states in 2001 (resolution WHA 54.21) is a classification of health and health-related domains which endorses the shift from a focus on diseases to persons by shifting the focus from cause to impact of diseases. The domains within ICF are classified from body, individual and social perspectives. ICF takes into account the social aspects of disability and does not see disability only as a 'medical' or 'biological' dysfunction. By including Contextual Factors, in which environmental factors are listed, ICF takes fully into account the impact of the environment on the person's functioning [4]. Currently, there is a need for a new balance between "person" and "people". The 2008 World Health Report "Primary Health Care: now more than ever" [5] contributed largely to this awareness by putting the concept of "people-oriented care" in the core of its message. The report mentions that people- centered care deals "with the whole person in their specific familial and community contexts." Attention has to be given to the totality of the person, *within a biopsychosociospiritual framework.* The report illustrates this with cases from all over the world (see Box 1). In the third chapter of the report "Putting people first", the general context of the debate on why people-centered care matters, is described [5].

This idea is further elaborated by a policy paper on people-centered health care written by the WHO Office of the Western Pacific Region. This paper emphasizes that health "is influenced by a complex interplay of physical, social, economic, cultural and environmental factors" [6]. This is also acknowledged in the ICF by the inclusion of a chapter on services, systems and policies in the list of environmental factors [4]. The document furthermore emphasizes the need to pursue developmental work on the following topics: equity and fairness in policies, the development of programs firmly grounded in ethical principles, the quality of health, human dignity and the role of the family, culture and society, amongst others [6].

Box 1: People-centered services [5]

> Health systems can be re-oriented to better respond to people's needs through delivery points embedded in communities. The Islamic Republic of Iran's 17,000 "health houses" each serve about 1,500 people and are responsible for a sharp drop in mortality over the last 2 decades, with life expectancy increasing to 71 years in2006 from 63 years in 1990. New Zealand's primary health care strategy launched in 2001 has as part of its core strategy an emphasis on prevention and management of chronic diseases. Cuba's polyclinics have helped to give Cubans one of the longest life expectancies (78 years) of any developing country in the world. Brazil's Family Health Program provides quality care to families in their homes, at clinics and in hospitals.

Nevertheless, the introduction of an emphasis on these concepts and a revision of existing bibliography on the topic of "PCC" gives the strong impression that the majority of the current analyses and debates does not go any further than the integration of the biopsychosocial components of health. Very little attention is given to the broader social, economic, cultural and environmental factors that shape health and healthcare. So it seems that there is a distinctive need to clarify different concepts that until now are used without discretion and distinction in the "PCC"-debate: is the "P" standing for "patient", "person" or "people"-centred care? This paper builds further on the previous work of WHO by designing a theoretical framework which identifies the major elements of people-oriented care. From this theoretical framework, "indicator-fields" are delineated and a first exercise to define specific indicators that could be used to assess the "people-centeredness" of health systems is made. We hope that this paper will intensify the debate on people-oriented care, its components and possible indicators and that it will contribute to the development of an instrument that can assess the *actual* "people-centeredness" of a health system. Such an instrument should be sensitive to change over time, in order to evaluate health systems' development and progress in terms of "people-centeredness."

Methods

A qualitative research method, using Delphi rounds, was used to develop the theoretical framework. Based on the two WHO publications described in the Introduction and on an exploration of the relevant literature, an initial framework was developed by JDM and CvW (FW1). In a first Delphi-round, FW1 was sent to the members of the International Centre for Primary Health Care and Family Medicine – Ghent University, a WHO Collaborating Centre. Based on their input, the framework was further developed (FW2) and FW2 was presented in a Workshop at the Fourth Geneva Conference on Person-centered Medicine (Geneva, April 30 - May 4, 2011). Feedback from the workshop participants was taken into account in the design of FW3 which was the base of a second Delphi round among the members of the CC on PHC and the authors of this paper (FW4). Two more Delphi rounds followed, resulting in FW5 and FW6. The latter version of the theoretical framework (FW6) formed the basis of this paper.

Results

The theoretical exploration based on relevant literature is presented in the Discussion under two headings: 'From patient to person' and 'From person to people'. Next, some system implications identified in the literature or emerging from the Delphi rounds, are presented. In the third part of the results, we describe the themes on which people-oriented care distinguishes itself from disease-, patient- or person-oriented care. These emerged from the Delphi rounds. These themes and their sub-themes are presented in Figure 1. In the "indicator-fields", which are formed on the crossing between the sub-themes and the levels on which care is designed or implemented (provider level, local level, national level, international level), suggestions for concrete indicators are included. They have the potential to be used to assess the "people-centeredness" of health systems.

Discussion

From patient to person

There were times and there still are currents in medicine where health is reduced to the "absence of sickness and diseases" and interventions were/are oriented towards taking away the symptoms of disease. Disease is hereby defined as "the condition of the living animal or plant body or of one of its parts that impairs normal functioning and is typically manifested by distinguishing signs and symptoms" [7]. The increasing evidence base on risk factors has even led to an increase in the labelling of apparently healthy people as *patients*, even without any pathological signs or symptoms. A disease-oriented intervention focuses on symptoms or "parts" of the human body and all too often reduces the ill person to being a patient: "an individual awaiting or under medical care and treatment" and "one that is acted upon" [9].

Development of patient-oriented communication skills enables physicians to understand the complexity of illness in the lives of individuals and their families [8,9]. This, but also the development of evidence-based guidelines and the contribution of other disciplines such as social workers, contributed to the ability of family physicians to understand better and deal more adequately with problems, for example, of depression, anxiety and insomnia. Essential in this is the recognition that persons may experience signs and symptoms – with impact on their functioning – after the disease has been resolved [10] which emphasizes, again, the need to focus not merely on the cause, but also on the impact of disease [4]. In other words, experienced symptoms and 'pathology' are not identical. The value of medical interventions has to be assessed against psychological and social interventions and abilities (coping, empowerment) and asks for a comprehensive approach, in particular for persons with psychosocial problems and persons with chronic physical conditions and, above all, in patients with multi-morbidity. By putting the person at the centre of the process, a repair-focussed, problem-oriented care is replaced by goal-oriented care [11,12]. This requires an integration of healthcare and social welfare.

The concept of "person" clearly refers to a wider dimension of the patient as a human being. It refers to a historically, socially, culturally, religiously determined philosophical concept of humanity [7]. With respect to health, Socrates already insisted that "if the whole is not well, it is impossible for the part to be well". So, healthcare has to focus on the totality of the person, within a biopsychosociospiritual framework. A relatively recent report by the Economist Intelligence Unit, sponsored by Philips, makes a clear plea for person-centred care [13]. Healthcare at the time of writing is directed to individuals with a disease and consequently the effectiveness of care is determined by the success of integrating interventions directed at the personal aspects with those directed at the health problem – i.e. understanding the context of the person with the disease. Here, the wise physician employs "contextual evidence" alongside the "medical evidence" [14]. The focus in person-centered care is on the complexity of the disease and on the individual, away from the narrow biomedical approach [15]. Taking into account the context makes it clear that there is, in the care of the patient, not a "universal truth" but all practice is local and contextual and requires evidence that matches the environment in which it has to be practised [16]. So, there is a need to leave the "micro-sphere". Yet, although the paradigm shift from the *patient* and his disease to the *person* is essential, it will be insufficient if it stops at the level of the individual. Essential to the concept of person-centered care is the need not to forget to take the healthcare provider as a person into account. Mezzich and colleagues describe person-centered medicine as a medicine *of* the person (the totality of the person's health, including its ill and

positive aspects), *for* the person (promoting the fulfilment of the person's life project), *by* the person (with clinicians extending themselves as full human beings, well grounded in science and with high ethical aspirations) and *with* the person (working respectfully in collaboration and in an empowering manner through a partnership of patient, family and clinicians) [17]. This definition, while clearly placing the patient and clinician(s) at the centre of care, does not exclude the consideration of other people influencing this care process (e.g., community, health policy).

From person to people

The African concept of "person-centeredness" is very interesting and facilitates the shift from "person" – to "people- centeredness": "Batho Pele" (Sesotho expression) means "people first" and is closely connected to the concept of "Ubuntu", translated incompletely as "in existing with and through others". It champions both the person and groups of persons by virtue of an interconnectedness expressed, for example, via the isiZulu expression "Unmuntu Ngumuntu Ngabantu": "I am because you are and you are because we are" [18]. People-centered care is consistent with this expression.

Persons live in a community with their specific values and cultures. Those communities are determined by social, economic and environmental factors. And social, economic and societal factors are major determinants of health and disease [19]. Individual risks and the wellbeing of persons living in a community are consequently shaped by their living and working environment. This means that knowing and understanding the social environment and its impact on health, illness and disease often provides the key to the care of persons. Knowing people's living environment makes it possible to identify high risks, establish the value of early detection and screening and prioritize diagnostic, therapeutic and care-supporting facilities. A profound understanding of the living, working and housing environment ('community diagnosis') is among the most powerful means of support for personal healthcare, a main factor to explain the effectiveness and efficiency of primary healthcare [20] and critical for health promotion and disease prevention.

Just as the concept of "person" is wider than that of "the patient", the definition of "people" is wider than that of "person". Grammatically seen, 'people' is plural and people's "attributes" are always collective: common needs, shared characteristics, collective plans and proposals, etc. People-centered care – by definition – also tackles and promotes the collective perspective on health and wellbeing, giving due attention to the social determinants of health, including economic and political aspects of health. Historically seen, "people-centered care" has been the core business of public health and social medicine since Hippocrates.

Some system implications

People-centered care encompasses and goes beyond the principles of person-centered care, patient-centeredness and attention to diseases. A quick review of the different concepts makes this clear as well as a brief review of how family medicine has been dealing with the patient and its symptoms, as a person, imbedded in its social context – be it the family, social group, ethnic community and country - which is shaped by its people. This implies that it is no longer pertinent to maintain the divide between "person-centered clinical medicine" on the one hand and "people-centered public health" on the other. The traditional divide between "personal healthcare" and "public healthcare" is artificial and non-productive in the healthcare system. Nowadays, the neo-liberal context unfortunately orientates care too much towards an approach focusing on the repair of the deficiencies of an individual, but omitting to look at the broader context. Moreover, an individual, confronted with high demands, increasingly has to learn to solve the problems himself/herself, as the health system comes under increasingly heavy economic pressure.

To overcome this traditional divide, there is a need for the integration of the population approach with the individual care approach. Primary care professionals have an essential role in bridging the gap between individual treatment of disease and community-oriented health actions. The interface between personal and community health is where primary-care practices should develop in the coming years [21]. Strengthening healthcare systems through primary healthcare means putting people at the centre of care [22]. We know that individual lifestyle interventions, such as smoking cessation and promotion of healthy diets, are most effective when they are re-inforced by supportive health policies (e.g. tobacco legislation, food quality surveillance systems) [16]. This illustrates the public-personal health interaction. Primary healthcare focusses on the population: the district, a practice population. In the pursuit of personal care, it needs to function with an orientation to the population, looking at the most important health problems and their determinants, planning of the most effective preventive and therapeutic interventions for and with the population and advocacy to improve living conditions, while still providing individual healthcare. Strategies such as community-oriented primary care [23] may contribute to equity and social cohesion [24].

There is a need for further research that enables the identification of health system conditions that are conducive for people-centered care. Nowadays, people-centered care is commonly understood by what it is not: it is not technology-centred, not doctor-centred, not hospital-centred, not disease-centred [25]. Maybe, one could add to this list of what it is not: the pursuit of short-term profit, an immediate return of money on investment, or a business-centred approach with claimable healthcare costs as its main focus of trade, that all lead to

Themes and subthemes	Health provider level	Local policy level	National policy level	International policy level
Proportional universalism				
Needs assessment	Providers ask for life and health priorities of persons attended and respect these whenever possible (e.g. when confronted with conflicting treatments in case of multi-morbidity).	Health promotion and service delivery at the local level is linked with the demands and actions of social movements and civil society organizations.	National priorities in health organization and financing are based on specific needs and (national) valorization of priorities.	International Declaration of Human Rights serves as common ground but the international community also respects the differences with regards to national priorities in health organization and financing,
High ethical aspirations (respect for diversity, people's autonomy, beneficence, non-malfeasance and justice)	The existence of an institutional policy of non-discrimination on grounds of language, race, appearance (e.g. albino), ethnic group, religion, underlying disease (e.g. psychiatric patients, lepra, HIV), gender/sex or sexual orientation. Health workers respect each patient independent from his/her cultural background, gender, sexual orientation, or any other individual difference. Local groups of health providers discuss issues related to a respectful attitude and behavior to each patient requesting healthcare. The institutional policy promotes and supports the use of the local language by the healthcare providers. When not possible the healthcare provider can be assisted by trained translators.	The existence of local policies and practices towards the elimination of discrimination based on religion, race, appearance (e.g. albino), ethnicity, socio-economic status, underlying disease (e.g. psychiatric patients, lepra, HIV), sex, gender and sexual orientation	National health policy takes into account cultural and gender diversity, and foresees strategies and actions to promote social equity and to prevent discrimination National guidelines and a legal framework are developed to guarantee a respectful care by all healthcare providers. Healthcare providers are educated and trained to use the local language during contact with their patients. An educational and training programme is developed for translators in a medical setting.	Respect for national differences in ethics, related to history, religion. E.g. decisions on end of life care. Promotion of research in poverty related and neglected diseases.
Incorporation of expertise and experiences in alternative and traditional practices	Institutional providers and health workers recognize the diversity of medical systems and approaches being used by their patients (traditional/regular, alternative, popular) and there is a respectful	Locally organized discussion forum, where regular medical staff and alternative health workers meet.	The existence of a national policy and program with regards to the recognition, training, certification and follow up of traditional/regular and alternative health workers (healers, birth attendants, etc.).	International guidelines on qualitative practice with respect for national valued alternative practices

Themes and subthemes	Health provider level	Local policy level	National policy level	International policy level
	recognition of both approaches concerning the limits and possibilities, accepting possible complementarities in promotion, prevention and treatment.			
Accessibility				
Outreaching	Health workers become involved in outreach activities in which people are reached within their communities, instead of only waiting for patients to come by (the hospital or health center). Health workers are enabled and rewarded economically for doing outreach health work (promotion, prevention, care & cure).	There exists a local policy towards the recognition of community health workers and informal care givers. Outreach activities are supported.	(Social and economic) recognition and support of informal care givers (e.g. women, buddy"s) involved in personal patient care.	
Geographical access		Local government organizes availability of geographical accessible primary care services with safe and accessible transport facilities. Health workers and communities are consulted in the planning of road constructions and priorities for maintenance with an eye on (urgent) medical access for all people in their area	National planning of road constructions and maintenance take into account the access to healthcare facilities.	
Financial access	Institutional policy promotes prescribing generic (cheaper and identical in quality) drug if available. Healthcare providers demonstrate an attitude to be/become independent from the promotional activities of pharmaceutical companies.	Local governments have special policies and programs oriented towards promoting economic access of minority and socially excluded groups to health programs and healthcare	Existence of a national social security and protection scheme that covers an important proportion of the population. The organization of the health financing avoids disproportionate individual „fee for service" or „out of pocket spending".	Adopting international regulations for the universal financial access to essential and generic medicines. International policies oriented towards reducing the commercialization in healthcare and prioritizing a human rights approach in healthcare (e.g. on the level of Free Trade Agreements

Themes and subthemes	Health provider level	Local policy level	National policy level	International policy level
			Laws and administration of justice exists on transparent public financing mechanisms of the health sector (given that health is a highly "corruption–vulnerable" sector) National health financing puts public interest above corporate private interest or profit.	Existence of bi- or multilateral social security agreements allowing migrants continue building up social security rights.
Psycho-social and cultural access	Health workers explore and take into account the meaning of illness and health to each individual patient (respecting cultural, gender & individual differences). There is a cultural and gender accordance (or at least availability) between health workforce and attended population.	Existence of local policies or programs promoting linguistic and cultural concordant consultations (eg. incentives for health workers working in places of origin; setting up of inter-institutional services for translation or cultural mediation). Support of patient empowerment and promotion of the creation of patient groups.	Integration of a cultural competence training program in the medical education curriculum and the professional training of all healthcare providers. National policies promote and reward the training, recruitment and retention of (the right type of) health workers where most needed. Special national policies and programs exist in order to enable access to health for minority and socially excluded groups.	
Continuity	Continuity of care is guaranteed, be it by the same health worker, same institutional provider, in coordination with others or by means of a global (electronic) patient health record.	Organization of an appropriate system of continuity of (emergency) care (24/24 hours; 7/7 days) is inter-institutionally organized at the local level.	An important proportion of GDP (?), spent on health is spent on primary healthcare.	Adoption of an international tax on financial transferences to scale up primary healthcare with a proportion of the yield. A relevant proportion of donor funding for health is oriented to development of the primary healthcare system. A significant proportion of donor funding goes to horizontal health programs and vertical health programs are progressively imbedded into horizontal initiatives.

Themes and subthemes	Health provider level	Local policy level	National policy level	International policy level
				International policies and programs position primary healthcare in a gate-keeping function to decline hospital-centrism approaches
Human resources	Person-centered care augments the satisfaction of the patient and relatives and is associated with higher provider professional satisfaction. Institutions can count on sufficient and adequate staff of health workers and resources to provide opportune and quality care.	Institutional or local policies oriented at creating enabling environments for (primary) healthcare workers: non-violence, appropriate working conditions, work-family balance, career perspectives, job rotation, etc.) Patient and provider safety is monitored at community level.	A primary healthcare policy is coherently traduced into (human) capacity and the development of adequate infrastructure. Existence of national policies towards training and retention of healthcare providers with primary healthcare profile. Appropriate nationally regulated working-conditions and statutes exist for health workers that reconcile responsiveness and flexibility with sustainability. Existence of a national policy for the sustainable training and financing of health workers. National policy in place on patient and provider safety and responsibility.	Existence of international policies and measures (economic compensation, working conditions, career perspectives, etc.) with regards to health workers" migration or „brain drain". Existence and/or ratification of international standards concerning decent working conditions, mental and medical support for health workers. Existence of international ethical recruitment and retention strategies.
Comprehen-siveness **Integration of services and systems** **Receptiveness for a broad range of health-related problems**	Health workers go beyond mere physical symptoms or "diseases" (e.g. conflicts or violence in the family).	Existence of horizontal cooperation between health and social services. Existence of PHC-teams, responsible for defined populations	Disease-orientated health programs are integrated in primary healthcare policies and programs. The planning of disease-oriented specialized programs incorporates an	Generic scenarios are developed to offer health authorities a framework to integrate existing vertical programs into the existing primary care facilities.

Themes and subthemes	Health provider level	Local policy level or districts.	National policy level evolution to the integration in the existing primary healthcare system.	International policy level
Attention for the social determinants of health	Healthcare workers pay attention to and act upon the broader social determinants of health (e.g. air pollution, living conditions, psychosocial stress caused by poverty)	Existence of inter-sectorial municipal social welfare and health plans.	Public Health goes beyond epidemiology and works on social determinants of health. Existence of national social accountability mechanisms of healthcare institutions.	All international policies and recommendations consider their social accountability
Importance of inter sectorial action	Existence and shared use of (electronic) medical & social welfare records makes inter sectorial coordination possible. Coordinated multidisciplinary teams are functioning at the institutional level.	Multidisciplinary (inter-institutional) teams and programs function with sufficient and pertinent health care providers and according to local health needs (specialists included).	Existence of inter-sectorial national social welfare and health plans. There exists inter sectorial cooperation at ministry level, dealing with health issues in their linkages with other sectors (education, work, housing) and variables (socio-economic, cultural, gender). A national policy and system with respect to the inter-operability of medical records is in place. Consensus exists on the common language used in the patient records to allow exchange of data in the whole country.	Integration of different sectorial UN strategy plans (ILO, WHO, UNDP, UNFPA) into a coherent national strategy framework and with a clear orientation towards human development and “caring” healthy societies.
Inclusion of health promotion and prevention	Institutional policies allow and reward healthcare workers for going beyond “treating symptoms” and getting involved into the (health of) the wider community. Health institutions are implementing a quality assessment of provider-people interactions in prevention, promotion, cure and care. Health workers are enabled and	Local welfare and coordination instances are functioning and exchanging information and community-diagnosis on health and social welfare.	A global plan is developed to establish specific health community actions. Incentives and support is organized to guarantee local patient participation.	

Themes and subthemes	Health provider level	Local policy level	National policy level	International policy level
	rewarded economically for doing integrating promotion and prevention, beside care & cure.			
Relevance of care				
Responsiveness and flexibility	Institutional providers are based on flexible organizational models that can respond to evolving needs.	Availability and coordination of information for prompt response is organized at the local level.	At the level of national health policy making, there is a clear orientation towards community oriented (primary health) in organizing responsive and continued health care.	Generic scenarios are developed and offered to health authorities and communities to develop, maintain and ameliorate community-oriented health initiatives.
Problem- and goal-oriented care balance	Health providers at different levels can cope with multimorbidity, look at patients' life goals gain and balance medical treatment goals with patient goals.	At the local level, a clear communication (on the content level and communication equipment) exists with second and third level of care, enabling goal oriented care coordinated at the primary care level.	Organization of training and education in multimorbidity and goal-oriented care.	
Contextual adequacy (effectiveness)	Health workers explore and take into account the meaning of illness and health to each individual patient (respecting cultural, gender & individual differences).			International humanitarian emergency aid is strongly integrated with and is strengthening national (health, food supply & other) systems.
Cost-effectiveness and cost-utility	Healthcare providers with a more person-centered attitude tend to prescribe less medication and refer less to other health workers.		Quality monitoring and improvement are part of the educational curriculum of health care workers and healthcare managers.	International health policy and recommendations pay attention to standards and guidelines for defining, monitoring and improving quality in healthcare.
Participation and empowerment				
Human rights as a pre-requisite	Providers know, promote and respect patient and human rights.	Local initiatives stimulate patient empowerment and support patient groups to explore their needs and expectations.	Human rights are integrated in national laws and respected in the administration of justice. In addition, a national patient's law is developed and regulated.	

Themes and subthemes	Health provider level	Local policy level	National policy level	International policy level
			Health and health rights issues are embedded in the general education curriculum at national level. Human rights and social equity issues are embedded in medical education (human rights, patient rights, social determinants of health, ethics, equity, social accountability).	
Health literacy and empowerment	Institutional policies that exist at the provider level are oriented towards empowering patients through information sharing, shared learning and decision-making.			
Leadership and participation		Independent social organizations working on and advocating for health exist at the local level and are supported by local policy makers.	There exists an institutionally recognized and active participation of civil society representatives in national health policy boards.	Civil society's input and participation in health policy development on the international level is recognized and promoted by multi-lateral organizations and bilateral cooperation.

fragmentation into vertical disease-oriented silos that are unable to inter-connect [26]. People- and person-centred healthcare forms a societal investment, aiming to strengthen communities and society at large. Its outcome, in terms of economic profits, should be measured against the powers of thriving communities to direct their own destinies.

Operationalizing the concept of "people-centered care"

There is a lack of consensus as to how people-oriented care distinguishes itself from disease-, patient- or person-oriented care, and - even less - on how to measure the level of people-centered care orientation of a healthcare system and/or its progress towards people-centered care [27]. There is an urgent need to define dimensions and indicators that can be used to set targets, monitor progress and evaluate the effectiveness of interventions. Based on a review of the literature, the feedback from the workshop at the 4th Geneva Conference and the Delphi-rounds, the International Centre for Primary Health Care and Family Medicine at Ghent University firstly identified themes and sub-themes which are essential in the assessment of the people-orientation of care. Consider then, the following:

- Healthcare must take into account the socially and culturally-defined differences amongst people, including gender differences, without discrimination. While *diversity* must be recognized and valorised, healthcare must also promote universally accepted
- values and rights and be available for all groups and people. The scale and intensity of action should be proportionate to the level of differences and the differences in health between social groups (*'proportional universalism'* [28]).
- Healthcare must be *accessible*, both in its physical and geographical, financial, psycho-social and cultural sense. The notion of equity is of paramount importance: those in highest need should receive all necessary care. Human resource management is a paramount health system condition to provide sufficient care and an appropriate health staff, including primary health workers to ensure accessibility to healthcare.
- Healthcare must be *comprehensive* and integrate the various facilities and services people require – primary care and specialist care, health and social welfare – and include promotion of health and prevention of disease (acting on social determinants of health) as well as maintaining an emphasis on curing diseases.
- People-centered care must provide *relevant care*, emphasing the importance of responsiveness and flexibility, a balance between problem- and goal-oriented care, effectiveness and cost-effectiveness and cost-utility. Prompt and pertinent response, as well as continuity of care, requires (inter-)institutional co-ordination and flexible organization models at all levels.
- Healthcare can only to a certain level act for patients.

In its operation, healthcare has to actively *involve and empower* the people it is serving – both on an individual and collective level. People- centered care respects patients' human rights, it promotes health literacy, leadership and active participation on all levels.

Secondly, levels on which healthcare is designed and provided are identified. They include: the *providers'* level where the interaction between health worker and patient takes place, the *local* healthcare organisation and delivery, the *national* health policies and the *international* policies and actions.

Thirdly, Figure 1 presents the "*indicator-fields*" which are formed by the crossing between the themes and sub-themes and the levels on which care is designed or implemented (provider level, local level, national level, international level) and suggestions for concrete indicators are presented. They illustrate the basic requirements of a people-based healthcare system.

Conclusion

The development of person-centred care is based on the principle that each human being is a unique autonomous entity, in illness as much as in health. This makes it impossible for medical care to focus on organ and body systems in isolation from a consideration of the whole person. In pursuing healthcare that is directed at the person, the situation of the human being in his social environment as part of clinical assessment becomes inescapably necessary [29-32]. And in order to be able to address the social, cultural and economic environment, it is mandatory that both individual, person-centred, healthcare as well as public health programs are inter-connected and built up from a people-centered perspective.

Family medicine, with its close ties to local communities, has developed a template from which the connection can be defined: care for all health problems in all stages for all persons and at all levels, promoting equity while respecting diversity; comprehensive approaches that integrate health and wellbeing; responsiveness and continuity of care; empowering people. Acknowledging the social determinants of health and disease and based on its ties with local communities, the primary care principle of a 'community diagnosis' as the framework of its care, is a helpful template to integrate a person-centred healthcare into a people-centered health system and delivery.

Talking about "people-centeredness" in health, leads us to consider the public organization of health, policy

making and the regulatory functions of governments, the social accountability of institutions, the active involvement of all stakeholders, including social organisations and other civil society actors, be it at the local, national or international level.

With this as its basis, a first approach of the literature and a number of Delphi rounds revealed themes and sub- themes essential in the assessment of the people-centeredness of healthcare systems, as well as a number of possible indicators to measure, value and monitor the progress towards people-centered health systems and healthcare. Further review of these themes, sub-themes and indicators and field testing are needed to develop robust tools in support of health policy setting.

References

[1] Preamble to the constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 states (Official Records of the World Health Organization n° 2, p. 100) and entered into force on 7 April 1948.

[2] McWhinney, I.R. (1989). A Textbook of Family Medicine. Oxford: Oxford University Press.

[3] Wonca Europe. The European definition of general practice/family medicine – 2005 edition. Available from: http://www.woncaeurope.org/Web%20documents/European%20Definition%20of%20family%20medicine/Definition%202nd%20ed%202005.pdf (accessed April 13, 2011)

[4] World Health Organization. (2001) International Classification of Functioning, disability and health. Geneva: World Health Organization. Available from: http://apps.who.int/classifications/icfbrowser (accessed December 14, 2011).

[5] World Health Organization. (2008). World Health Report. Primary Care: now more than ever. Geneva: World Health Organization. Available from: http://www.who.int/whr/2008/en/index.html (accessed December 14, 2011).

[6] World Health Organization Western-Pacific Region. (2009). People-centred Health Care. A Policy Framework. Manila: World Health Organization Western-Pacific Region.

[7] Merriam Webster dictionary. Available from: http://www.merriam-webster.com/dictionary/ (accessed April 14 , 2011).

[8] Stuart, A., Brown, J.B., Donner, A., McWhinney, I., Oater, J., Weston, W.W. & Jordan, J. (2000). The impact of patient centered care on outcomes. *Journal of Family Practice* 49,796-804.

[9] Deveugele, M., Derese, A., Vanden Brink-Muinen, A., Bensing, J. & De Maeseneer, J. (2002). Consultation length in general practice: cross sectional study in six European countries. *British Medical Journal* 325, 472-477.

[10] van Weel-Baumgarten, E.M., van den Bosch, W.J.H.M., van den Hoogen, H.J.M. & Zitman, F.G. (2000). The long-term perspective: a study of psychopathology and health status of patients with a history of depression, more than 15 years after their first episode. *General Hospital Psychiatry* 22, 399-404.

[11] Mold, J.W., Blake, G.H. & Becker LA. (1991). Goal-Oriented Medical Care. *Family Medicine* 23 (1) 46-51.

[12] Boeckxtaens, P., Bekaert, S., De Sutter, A. & De Maeseneer, J. (2011). Translational Research and Multi-Morbidity: need for a paradigm-shift. *International Journal of Public Health*. In press.

[13] Economist Intelligence Unit. (2009). Fixing Healthcare: The Professionals' Perspective. London: The Economist.

[14] De Maeseneer, J.M., van Driel, M.L., Green, L.A. & van Weel, C. (2003). The need for research in primary care. *The Lancet* 362, 1314-1319.

[15] Heath, I., Rubinstein, A., Stange, K.C. & van Driel,
M.L. (2009). Quality in primary health care: a multi-dimensional approach to complexity. *British Medical Journal* 338, 911-913.

[16] van Weel, C., Roberts, R. & De Maeseneer, J. (2011). Practice and research, seeking common ground to benefit people. *Family Practice* In press.

[17] Mezzich, J.E., Snaedal, J., van Weel, C., Botol, M. & Salloum, I. (2011). Introduction to person centered medicine: from concepts to practice. *Journal of Evaluation in Clinical Practice* 17, 330-332.

[18] Van Staden, W. (2011). African approaches to an enriched ethics of person centered health practice. *International Journal of Person centered Medicine* 1 (1) 14-19.

[19] Commission on Social Determinants of Health. (2008). Closing the gap in a generation. Geneva: World Health Organization. Available on: http://www.who.int/social_determinants/thecommission/finalreport/en/index.html (accessed on 10 December 2011).

[20] Stange, K.C. & Ferrer, R.L. (2009). The Paradox of Primary Care. *Annals of Family Medicine* 7, 293-299.

[21] van Weel, C., De Maeseneer, J. & Roberts, R. (2008). Integration of Personal and Community Health Care. *The Lancet* 372, 871-872.

[22] WHO Sixty-Second World Health Assembly. Primary health care, including health system strengthening. Geneva: WHO WHA62.12. Available from: http://www.wpro.who.int/NR/rdonlyres/A14645A1-BF7D-4EF6-A6B5-58D2D75A99DF/0/WHARes6212.pdf (accessed April 13, 2011).

[23] Rhyne, R., Bogue, R., Kukulka, G. & Fulmer, N. (1998). Community-Oriented Primary Care: health care for the 21st century. Washington DC: American Association of Public Health.

[24] Art, B., De Roo, L. & De Maeseneer, J. (2007). Towards Unity for Health Utilising Community Oriented Primary Care in Education and Practice. *Education for Health* 20, 1-10.

[25] Groves, J. (2010). International Alliance of Patients Organizations' perspectives on person centered medicine. *International Journal of Integrated Care*; 10 (Supplement) e01. Available on: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2834902/

[26] De Maeseneer, J., Van Weel, C., Egilman, D.,

Mfenyana, K., Kaufman, A., Sewankambo, N. & Flinkenflögel, M. (2008). Funding for primary health care in developing countries. *British Medical Journal* 336, 518-519.

[27] WHO. (2010). People centered Care in low and middle income countries. Third Geneva Conference on person-centered Medicine. Technical Report of meeting, 5 May 2010.Available on: http://www.personcenteredmedicine.org/docs/geneva2011i.pdf

[28] Marmot, M., Atkinson, T., Bell, J. et al. (2010). Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010. London: The Marmot Review.

[29] Miles, A. & Mezzich, J.E. (2011). The care of the patient and the soul of the clinic: person-centered medicine as an emergent model of modern clinical practice. *International Journal of Person Centered Medicine* 1 (2) 207-222.

[30] Miles, A. & Mezzich, J.E. (2011). The patient, the illness, the doctor, the decision: negotiating a 'new way' through person-centered medicine. *International Journal of Person Centered Medicine* 1 (4) 637-640.

[31] Miles, A. & Mezzich, J.E. (2012). Person-centered medicine: addressing chronic illness and promoting future health. *International Journal of Person Centered Medicine* 2 (2) 149-152.

[32] Miles, A. (2012). Person-centered medicine – at the intersection of science, ethics and humanism. *International Journal of Person Centered Medicine* 2 (3) 329-333.